The Commonwealth of Massachusetts
Bureau of Health Professions Licensure
**Board of Registration in Dentistry**
250 Washington Street
Boston, MA 02108
(617) 973-0971
www.mass.gov/dph/dentalboard

# INITIAL (FIRST-TIME) FULL-TIME FACULTY LIMITED LICENSE APPLICATION INSTRUCTIONS

(See 234 CMR 4.05 Effective August 20, 2010)

A full- time Faculty Limited License allows a full-time faculty member to perform all the duties of a dentist but only in a specifically-named hospital, school, public clinic, or prison. Private practice is not permitted at any time. Full-Time Faculty Limited Licenses are valid for exactly one year from date of issue and may be re-applied for annually. The Board may issue a Full- Time Faculty Limited License provided it receives the following documentation:

- An accurate, complete, and signed application including CORI report.
- Payment of a nonrefundable, nontransferable licensing fee.
- Proof satisfactory to the Board that the applicant has received a diploma in dentistry
  Graduates of non-CODA or foreign dental schools shall submit an original transcript, with college seal that indicates the date of issuance of a dental diploma from a reputable dental college. If the transcript is not in English, the applicant shall provide a certified translated copy of the original dental college transcript demonstrating the applicant received a dental degree from a reputable dental college.
- A full-time member of faculty shall submit an original letter with the college seal that confirms the applicant's status and dates of appointment as a full-time faculty member. The application for licensure shall also include the printed name, signature and license number of the applicant's supervising dentist, who shall hold a valid license issued by the Board pursuant to M. G. L. c. 112, § 45 and be in good standing with the Board.
- Documentation demonstrating current certification in American Red Cross Cardiopulmonary Resuscitation/Automated External Defibrillation for the Professional Rescuer (CPR/AED) or current certification in the American Heart Association Basic Life Support for Healthcare Providers (BLS).
- If the applicant has graduated from a dental school where the language of written or oral instruction (including textbooks) or both, is in a language other than English, the applicant shall submit documentation satisfactory to the Board that the applicant has achieved a minimum score, as specified by the Board, on a Board-designated test of English proficiency.
- A physician's statement that is the result of an examination, conducted within six months of the date of application, attesting to the health of the applicant and reporting impairments which may affect the applicant's ability to practice dentistry.
- If applicable, certified letters of standing from all jurisdictions in which the applicant has ever been issued a license to practice dentistry attesting to the standing of his/her license, including report of any past or pending disciplinary action, or any pending complaints against the applicant.
- A practice history, if applicable.

- An original report from the National Practitioner Data Bank (NPDB) Self-query.
- A statement disclosing any disciplinary action, civil and/or criminal action taken against the applicant at any time prior to the date of application, with supporting documentation as may be required by the Board.
- Successful completion of the Massachusetts Dental Ethics and Jurisprudence Examination. Email the Board at dentistry.admin@state.ma.us to request a copy of the exam.
- Attach a passport-size photograph in color (2x2) to application where indicated. See http://travel.state.gov/passport/guide/composition/composition_874.html
- An affidavit, signed under pains and penalties of perjury, and witnessed by a Notary Public.

**PLEASE NOTE:**

- Incomplete applications will delay license processing.
- Please retain a copy of all application materials for your records.
- Upon board approval, a certificate and a license number will be issued in your name and sent to your supervising dentist. Confirmation of your license number will be available under "Online Services/Check a License" on our website **www.mass.gov/dph/dentalboard** as soon as the Board approves the license.
- To contact potential employers or dental educational programs or educational opportunities

| | |
|---|---|
| Hospitals | **www.mahospitalcareers.com** |
| Community Health Centers | www.massleague.org |
| Massachusetts Department of Corrections | www.mass.gov/doc |
| Harvard University School of Dental Medicine | www.hsdm.harvard.edu |
| Boston University Goldman School of Dental Medicine | www.bu.edu/dental/ |
| Tufts University School of Dental Medicine | www.tufts.edu/dental/ |

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BOARD USE ONLY

Receipt #_____

Fee :_____

Jurisprudence: Pass _____ Fail _____

# APPLICATION
## INITIAL (FIRST-TIME) FULL-TIME FACULTY LICENSE

1. APPLICANT NAME:_____
(Last) (First) (Middle)

2. MAIDEN NAME/OTHER NAME:_____

3. ADDRESS OF RECORD:_____
(No.) (Street) (Apt #) (City or Town) (State or Country) (Zip Code)

**Note:** The address of record may be home or business and is, by law, public information.

4. MOST RECENT PREVIOUS ADDRESS: _____

5. TELEPHONE NUMBER AND EMAIL ADDRESS: Day:_____ Cell:_____

Email Address: _____

6. _____/_____/_____ _____ EYE COLOR: _____
Date of Birth (mm/dd/yyyy) Place of Birth (city/state/country)

HEIGHT: ____ Feet ____ Inches WEIGHT: ____ Lbs. MOTHER'S MAIDEN NAME: _____

7. SOCIAL SECURITY NUMBER (SSN) (**disclosure is mandatory**): _____/_____/_____
Pursuant to M.G.L. c. 62C, s. 47A, the Division of Health Professions Licensure is required to obtain your SSN and forward it to the Massachusetts Department of Revenue. The Department of Revenue will use your SSN to ascertain whether or not you are in compliance with Massachusetts tax laws (M.G.L. c. 62C, s. 47A) and child support laws (M.G.L. c. 119A, s.16).

## EDUCATION

8. GRADUATE OF: _____
Name of Dental School

_____
Street City State/Province Postal Code Country

9. DATE DENTAL DEGREE CONFERRED DATE _____ DEGREE _____
MM/DD/YYYY

**ALL APPLICANTS MUST ATTACH:**

**AN OFFICIAL TRANSCRIPT OF ORIGINAL DEGREE OR LETTER FROM YOUR DENTAL SCHOOL INCLUDING DATE (MONTH, DAY, YEAR) OF GRADUATION AND DEGREE CONFERRED; AND,**

**IF APPLICABLE, AN ACADEMIC CREDENTIALS EVALUATION IN ENGLISH.**

## VERIFICATION OF OTHER LICENSES/BOARD REGISTRATIONS

10. LIST BELOW ALL PROFESSIONAL LICENSES OR REGISTRATIONS INCLUDING PROFESSIONS OTHER THAN DENTISTRY WHETHER OR NOT YOU HAVE PRACTICED UNDER THAT LICENSE OR REGISTRATION.

NOTE: Applicants must obtain official verification of each professional license or registration from each state or jurisdiction and submit it with this application.

☐ **I DO NOT CURRENTLY HOLD AND HAVE NEVER HELD A PROFESSIONAL LICENSE OR CERTIFICATION IN ANY STATE OR JURISDICTION**

☐ **I CURRENTLY HOLD AND HAVE A PROFESSIONAL LICENSE OR REGISTRATION AS FOLLOWS:**

| Issuing Jurisdiction | Profession | License/Certification Number |
|---|---|---|
| | | |
| | | |
| | | |

## PRACTICE LOCATION(S)

12. (A). NAME OF SPONSORING INSTITUTION/CLINIC _____

ADDRESS _____

PHONE# _____ PRACTICE TO BEGIN: _____
MM/DD/YYYY

SUPERVISING DENTIST NAME _____

MASSACHUSETTS DENTAL LICENSE #DN_____

***I CERTIFY, UNDER PAINS AND PENALTIES OF PERJURY, THAT THE INFORMATION I HAVE PROVIDED PURSUANT TO THIS APPLICATION FOR LICENSURE IS TRUTHFUL AND ACCURATE.***

SUPERVISING DENTIST SIGNATURE_____

12. (B). OTHER AFFILIATED PRACTICE LOCATION _____

ADDRESS _____

PHONE# _____ PRACTICE TO BEGIN: _____
MM/DD/YYYY

SUPERVISING DENTIST NAME _____

MASSACHUSETTS DENTAL LICENSE #DN_____

***I CERTIFY, UNDER PAINS AND PENALTIES OF PERJURY, THAT THE INFORMATION I HAVE PROVIDED PURSUANT TO THIS APPLICATION FOR LICENSURE IS TRUTHFUL AND ACCURATE.***

SUPERVISING DENTIST SIGNATURE_____

12. (C). OTHER AFFILIATED PRACTICE LOCATION _____

ADDRESS _____

PHONE# _____ PRACTICE TO BEGIN : _____
MM/DD/YYYY

SUPERVISING DENTIST NAME _____

MASSACHUSETTS DENTAL LICENSE #DN_____

***I CERTIFY, UNDER PAINS AND PENALTIES OF PERJURY, THAT THE INFORMATION I HAVE PROVIDED PURSUANT TO THIS APPLICATION FOR LICENSURE IS TRUTHFUL AND ACCURATE.***

SUPERVISING DENTIST SIGNATURE_____

## ATTESTATION OF COMPLIANCE WITH 234 CMR 4.05(5) EDUCATION REQUIREMENTS

13. CHECK THE APPLICABLE BOX BELOW. THEN SIGN TO INDICATE YOUR CERTIFICATION OF THE CHECKED STATEMENT. THE SIGNATURE OF THE SUPERVISING DENTIST IS ALSO REQUIRED ON THIS PAGE.

☐ I certify, under pains and penalties of perjury that I have completed or shall complete, within one year of the date of initial licensure, all of the following continuing education units (CEUs):

A minimum of 3 CEUs in *CDC Guidelines*;
A minimum of 3 CEUs in OSHA Standards at 29 CFR;
A minimum of 6 CEUs in treatment planning and diagnosis;
A minimum of 3 CEUs in record-keeping;
A minimum of 2 CEUs in risk management; and
A minimum of 3 CEUs in pharmacology with emphasis on prescription writing;

OR

☐ I certify, under pains and penalties of perjury that I am enrolled in a CODA-accredited dental school academic program that includes all areas of study listed above.

_____ _____
NAME OF SCHOOL GRADUATION YEAR

**REQUIRED SIGNATURES:**

_____
SIGNATURE OF APPLICANT

_____
SIGNATURE OF SUPERVISING DENTIST AS WITNESS TO APPLICANT'S ATTESTATION

## GOOD MORAL CHARACTER QUESTIONS

**IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS PLEASE ATTACH A SEPARATE SHEET EXPLAINING THE CIRCUMSTANCES. ALSO PROVIDE ALL RELEVANT CERTIFIED DOCUMENTATION (POLICE REPORTS, COURT RECORDS, DISCIPLINARY ACTION REPORTS, ETC.) INCLUDING FINAL DISPOSITION OF THE MATTER.**

NOTE: An applicant for employment or for housing or an occupational or professional license with a sealed record on file with the commissioner of probation may answer 'no record' with respect to an inquiry herein relative to prior arrests, criminal court appearances or convictions. An applicant for employment or for housing or an occupational or professional license with a sealed record on file with the commissioner of probation may answer 'no record' to an inquiry herein relative to prior arrests or criminal court appearances. In addition, any applicant for employment or for housing or an occupational or professional license may answer 'no record' with respect to any inquiry relative to prior arrests, court appearances and adjudications in all cases of delinquency or as a child in need of services which did not result in a complaint transferred to the superior court for criminal prosecution.

14. Have you ever applied for and been denied a professional license in the United States or any country or foreign jurisdiction?

Yes ☐ No ☐

15. Has any licensing or certification board, government authority, hospital or health care facility or professional medical association located in the United States or any country or foreign jurisdiction taken any disciplinary action against you?

Yes ☐ No ☐

16. Are you the subject of pending disciplinary actions by any licensing or certification board, government authority, hospital or health care facility or professional medical association located in the United States or any country or foreign jurisdiction?

Yes ☐ No ☐

17. Have you ever voluntarily surrendered any professional license or board certification in the United States or any country or foreign jurisdiction?

Yes ☐ No ☐

18. Have you ever been arrested, charged, arraigned, indicted, prosecuted, convicted or been the subject of any criminal investigation or any court proceeding in relation to any criminal violation? Do not report minor violations for which a fine of $100 or less was imposed.

Yes ☐ No ☐ No Record ☐

## RELEASE

I hereby authorize all hospitals, institutions, credentialing agencies, organizations, personal physicians, employers (past and present), business and dental associates (past and present), and all government agencies and entities (local, state, federal, or foreign) to release to the Board of Registration in Dentistry any information, files or records requested by the Board in connection with the processing of my application. I further authorize the Board of Registration in Dentistry to release information contained in this application in association with its processing.

## AFFIDAVIT OF APPLICANT

To the best of my knowledge and belief, I have filed all state tax returns and paid all state taxes required by state law and do not owe child support. I am aware of my professional obligations under M.G.L. c. 119 s. 51A, the reporting of suspected child abuse.

I understand that the Board is certified by the Massachusetts Criminal History Systems Board for access to Criminal Offender Record Information (CORI), including conviction and pending criminal case data. As an applicant for a license to practice as a full-time faculty limited licensed dentist I understand that a CORI check may be conducted by the Board for conviction and pending criminal case information only and that the CORI results will not necessarily disqualify me.

I understand that I am responsible for reading and understanding the laws and regulations governing practice as a full-time faculty limited licensed dentist in Massachusetts and I hereby agree to comply with such laws and regulations.

I understand that this application for licensure shall be deemed no longer valid if requirements for licensure as a full-time faculty limited licensed dentist are not met within one (1) year from the date of Board receipt. I also understand that fees are non-refundable and non-transferable.

I certify, under the pains and penalties of perjury, that the information I have provided pursuant to this application for licensure is truthful and accurate. I understand that any failure to provide truthful and accurate information in connection with this application for licensure may be grounds for the Board of Registration in Dentistry to deny issuance of a license; to suspend or revoke a license issued to me; and to deny renewal of a license issued to me, all in accordance with Massachusetts law.

**To be completed, signed and witnessed by the applicant and a Notary Public.**

APPLICANT SIGNATURE _____ DATE _____

PRINT NAME _____

**Attach a recent color 2"x 2" passport-sized Photo**

NOTARY PUBLIC NAME: _____

NOTARY PUBLIC COMMISSION EXPIRES: _____ [Seal or Stamp]

**SUBMIT A NONREFUNDABLE AND NONTRANSFERABLE FEE FOR $90 (CHECK OR MONEY ORDER ) PAYABLE TO THE COMMONWEALTH OF MASSACHUSETTS**

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Bureau of Health Professions Licensure
Board of Registration in Dentistry
250 Washington Street, Boston, MA 02108

**CHARLES D. BAKER**
Governor
**KARYN E. POLITO**
Lieutenant Governor

Tel: 617-973-0971
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www.mass.gov/dph/dentalboard

**MARYLOU SUDDERS**
Secretary
**MARGRET R. COOKE**
Commissioner

# CRIMINAL OFFENDER RECORD INFORMATION (CORI) ACKNOWLEDGEMENT FORM

## TO BE USED BY ORGANIZATIONS CONDUCTING CORI CHECKS FOR EMPLOYMENT, VOLUNTEER, SUBCONTRACTOR, LICENSING, AND HOUSING PURPOSES.

The Board of Registration in Dentistry is registered under the provisions of M.G.L. c. 6, § 172 to receive CORI for the purpose of screening current and otherwise qualified license applicants and current licensees.

As a prospective or current license applicant or current licensee, I understand that a CORI check will be submitted for my personal information to the Department of Criminal Justice Information Systems (DCJIS). I hereby acknowledge and provide permission to the Board of Registration in Dentistry to submit a CORI check for my information to the DCJIS. This authorization is valid for one year from the date of my signature. I may withdraw this authorization at any time by providing written notice of my intent to withdraw consent to a CORI check.

FOR EMPLOYMENT, VOLUNTEER, AND LICENSING PURPOSES ONLY:
The Board of Registration in Dentistry may conduct subsequent CORI checks within one year of the date this Form was signed by me provided, however, that Board of Registration in Dentistry must first provide me with written notice of this check.

By signing below, I provide my consent to a CORI check and acknowledge that the information provided on Page 2 of this Acknowledgement Form is true and accurate.

_____
SIGNATURE

_____
DATE

NOTE: The Board of Registration in Dentistry cannot accept this form unless it is either (1) signed in person at the Board's offices in the presence of a BHPL employee who has verified the applicant's identity through acceptable identification, or (2) signed in the presence of a notary public who has likewise verified identity and then mailed or hand-delivered to the Board's offices at the address set forth above.

CRIMINAL OFFENDER RECORD INFORMATION (CORI)
ACKNOWLEDGEMENT FORM

SUBJECT INFORMATION: (An asterisk (*) denotes a required field)

*Last Name *First Name Middle Name Suffix

Maiden Name (or other name(s) by which you have been known)

Date of Birth Place of Birth

Last Six Digits of Your Social Security Number: _____-_____

Sex: ____ Height: ___ft. __ in. Eye Color: _____ Race: _____

Driver's License or ID Number: _____ State of Issue: _____

Mother's Full Name (Mother's Maiden Name) Father's Full Name

Current and Former Addresses:

Street Number & Name City/Town State Zip

Street Number & Name City/Town State Zip

The identity of the subject of this acknowledgement form was verified by reviewing the following form(s) of government-issued identification:

VERIFIED BY: _____ ON _____
Name of Verifying BHPL Employee or Notary Public (Please Print) Date

_____
Signature of Verifying BHPL Employee or Notary Public

NOTARY NAME: _____

COMMISSION EXPIRES: _____ [Seal or stamp]

## ATTACHMENT CHECKLIST

*Your application cannot be processed without all of the following:*

☐ **Attachment 1: Licensing Fee** - Personal or business check or money order made payable to the Commonwealth of Massachusetts for $90.00. Cash is not accepted. All fees are nonrefundable and nontransferable. Please do not staple check or money order to the application.

☐ **Attachment 2: Proof of Graduation from a Dental School** - Provide an official transcript or letter from your dental school including date of graduation and degree conferred, and translated into English, if necessary. Photocopies will not be accepted. Diplomas will not be accepted.

☐ **Attachment 3: English Language Proficiency** - If your dental degree is from a school where instruction (written or oral) was in a language other than English, documentation of a minimum score on the TOEFL or the academic format IELTS must be attached.
**Test of English as a Foreign Language** (TOEFL)
**90** (internet-based) **OR 577** (paper-based)
**OR**
**Academic Format International English Language Testing System** (IELTS) **7.0**

☐ **Attachment 4: Physician's Statement** - Signed statement on physician's stationery certifying that the candidate has been examined within 6 months prior to the date of application and is deemed fit to practice dentistry.

☐ **Attachment 5: Documentation of Current CPR/AED for the Professional Rescuer or Current BLS Certification**

☐ **Attachment 6: Massachusetts Dental Ethics and Jurisprudence Exam**—Answer sheet only.

☐ **Attachment 7: Confirmation of Full-Time Faculty Appointment** - An original letter signed by a school official on institutional stationery, including dates of faculty appointment.

**IF APPLICABLE**

☐ **Attachment 8: Proof of the successful completion of a Board-approved continuing education course on safe and effective opioid prescribing/pain management.** Refer to the Board's website at www.mass.gov/dph/dentalboard for info on how to access Board-approved courses; click on the link for "Alerts" then "PMP & Mandatory Educational Requirements for Prescribers."

☐ **Attachment 9: Letters of Standing** – Verification of Professional Licensure from each state or jurisdiction in which you hold or have ever held a license must be included in the application. The letter of verification of licensure must include the current status of the license, license number, the official seal of the jurisdiction's licensing Board, and any disciplinary actions taken. A photocopy of a license is not acceptable.

☐ **Attachment 10: Practice History** - If you have ever practiced dentistry in another jurisdiction or state, please include an up-to-date resume or practice history, including employers' contact information and dates of employment.

☐ **Attachment 11: National Practitioner Data Bank Self-Query Report** – (If you have ever held a professional healthcare license in the United States) To request a self-query report, please contact the Data Bank at 1-800-767-6732 or www.npdb-hipdb.hrsa.gov. The Data Bank will mail the report to you. Only an original report from NPDB will be accepted for this application.